DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	08E029	A. BUILDING _____ B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOVERNOR BACON HEALTH CENTER	248 KENT AVE DELAWARE CITY, DE 19706

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from January 4, 2017 through January 11, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was sixty (60). The survey sample totaled twenty-four (24). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; UM - Unit Manager; MD - Medical Doctor; RNAC - Registered Nurse Assessment Coordinator; CNA - Certified Nurse's Aide; FSD - Food Service Director; RD - Registered Dietitian; NP - Nurse Practitioner; PA - Physician Assistant; QA - Quality Assurance; ADLs - Activities of Daily Living, such as bathing and dressing; PRN - As needed; MAR - Medication Administration Record (on paper); TAR - Treatment Administration Record (on paper); eMAR - Electronic Medication Administration Record (in the computer); EMR - Electronic Medical Record; MDS - Minimum Data Set (standardized	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 assessment tool used in nursing homes); ROM - Range of motion, extent to which a joint can be moved safely; HS - At bedtime; cm (cubic centimeters) - unit of measurement; DSAMH - Division of Substance Abuse and Mental Health; PASRR - Pre-admission Screening and Resident Review; GDR - Gradual Dose Reduction; NADS - Nurse Aide Data Sheets; POS-physician order sheet; Anxiety - general unpleasant state of feeling worry, nervous or restless; Cognitive - related to the mind; Dementia - severe state of cognitive impairment characterized by memory loss, poor judgement, disorientation and personality changes; Huffing - inhaling chemicals; Psychiatrist - medical doctor with special training in psychiatry who can order medications; Psychological - related to the mind; Psychologist-Psych - person with advanced degree who treats mental disorders with psychotherapy; Psychosis/psychotic - loss of contact with reality; Skype-have a conversation with someone over the internet using a software application; 1:1-care provider to a resident with the ratio of one resident to one care giver over the entire shift.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 166		4/14/17

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F 166	Continued From page 2 (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing	F 166		

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F 166	Continued From page 3 written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the	F 166		

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F 166	Continued From page 4 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R44) out of 24 residents the facility failed to promptly address a resident's concern. Findings include: The facility's policy for Resident Concerns/Grievances included "The nurse in charge of the unit will complete a concern form referral to the Social Service Administrator and the original will be brought to the next clinical morning meeting. Management will work with the resident/family/guardian to attempt to find a satisfactory solution to the issue. Resident/family/guardian will be notified in writing of the proposed resolution." The following was reviewed in R44's clinical record: 12/6/16 - Quarterly MDS documented the resident was cognitively intact. 12/28/16 2:45 PM - Nurse's note documented ...making false accusations about resident (initial's of accused residents) stealing her gifts from Christmas. Stated she was not anxious. Resident requesting lock for closet. 1/4/17 1:15 PM - Nurse's note documented ...approached another resident (initials) she told (initials) "you better bring back my jewelry you stole from me by the time I get back from therapy" This writer escorted resident to her room and told her the jewelry would be found. Resident	F 166	F166 RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES Individual Resident Impacted The resident reported jewelry and Christmas presents were missing. Resident also requested a lock for her closet. The facility failed to follow up and complete an incident report and investigation. A lock was not ordered. Lock place on closet. Items replaced. Identification of other residents having the potential to be affected All residents have the potential to be affected. After reviewing the charts, no other residents were found to be affected. Systemic Changes Root Cause: Nursing notes stated the residents complain of missing belongings. An incident report with follow up investigation was not completed because staff thought it was related to the resident making false allegations. The careplan lacked evidence of a behavior of false accusations. The care plan was revised to include this behavior. Systemic changes put in place to ensure the deficient practice does not recur: Staff will complete an incident report when items are missing. Staff will not let	

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F 166	Continued From page 5 stated "I'm tired of pussy footing around with her" 1:1 provided with minimal results... An interview with R44 on 1/4/17 at 2:38 PM when asked if she has had any missing personal property he/she stated a necklace and a chain with lock and heart. R44 further stated that she reported this to staff and that they were still looking for it. Review of resident clothing inventory lists did not have any jewelry noted. Recent clothing and CD player/clock radio was added as Christmas presents in 2016. An interview on 1/09/17 at 10:01 AM with E15 (RN, UM) revealed that the resident was currently "cycling" with psychological problems and targets specific people when that happens. E15 stated the resident never told them exactly what was missing and that an incident/concern form was not initiated. A follow-up interview at 10:10 AM with E15 revealed that staff checked R44's room and found a necklace with a key on it but no other necklaces. R44 also made a new allegation that an antique necklace her father brought in two weeks before Christmas was missing. At 10:17 AM on 1/9/17 it was confirmed that the father had been deceased for several years and the brother denied that any such necklace existed. Review of the record including the care plan lacked evidence of a behavior of false allegations. An interview on 1/10/17 at 1:19 PM with E2 (DON) about the allegation of missing necklaces revealed that she felt the incident never happened and the allegations were a result of medication changes and the cycling of a mental	F 166	resident□s behaviors of false accusations prevent them from completing an incident report for missing property. The Resident Grievance policy has been updated. The RN supervisors will meet with staff and review incident report requirements; Compliance with the updated grievance policy will be reviewed. Corrections to be monitored to ensure the deficient practice will not recur: Monitoring of incident reports will be completed and information from the monthly resident council meeting will be reviewed. Success Evaluation Monitoring of incident reports will be completed and information from the monthly resident council meeting will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	

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F 166	Continued From page 6 disorder. It was however confirmed that R44's missing items were not addressed as a resident concern. These findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 166		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by:	F 167		2/17/17

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F 167	Continued From page 7 Based on observation and interview it was determined that the facility failed to ensure that survey results were accessible to residents in wheelchairs and failed to ensure a posting of the the location of the survey results was displayed in public view. Findings include: During initial tour on 1/4/17 around 9:00 AM it was noted that the past 3 years survey results were in binders in baskets attached to the wall on all three resident units and near the main entrance, at a level too high for residents in a wheelchair. There was no posting found in a public area indicating where the survey results were located. An interview on 1/11/17 at 11:45 AM with E2 (DON) confirmed the survey postings may not be accessible to residents in wheelchairs and that the only posting of survey result location was on the survey binders themselves. These findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM. E2 revealed that the binders had been lowered and a public notice of location had been posted.	F 167	F167 Comprehensive Assessments Individual Resident Impacted Three (3) years of the most recent surveys were posted in public areas on the units and main entrance; unfortunately it may have been too high for residents or visitors in wheel chairs to readily access. Identification of Other Residents with Potential to be Affected All residents living at GBHC have the potential to be affected. Systemic Changes When it was brought to our attention on 1/10/17, Maintenance immediately lowered all baskets where the surveys were kept and signs were posted over the baskets showing the survey results. GBHC Administration will also re-evaluate if surveys need to be posted on all three (3) nursing units. Success Evaluation GBHC surveys will be publicly posted with a sign on the wall at the main entrance of the facility. Quality Assurance Administrator will do monthly checks for placement of the signs and the basket with GBHC recent surveys. These findings will be reviewed at the quarterly Quality Assurance (QA) Committee meetings.	
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		2/3/17

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F 253	Continued From page 8 (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for 4 (107, 122, 132 and 209) out of 22 rooms reviewed, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. Findings include: Observations were made during Stage 1 on 1/4/17 between 9:00 AM and 3:00 PM, on 1/7/17 between 9:00 AM and 1:00 PM and on 1/11/17 between 10:00 AM and 10:28 AM found: - 2 (107 and 209) rooms with moderate wall/door frame scuffing/peeling paint. - 1 (107) room with soiled privacy curtain. - 1 (122) room with moderate damage to baseboard. - 1 (132) room with severe staining on bathroom floor. - 1 (209) room with missing floor tile under sink. Findings were confirmed in interview with E8 (Maintenance Director) and E9 (Housekeeping Director) on 1/11/17 between 10:30 AM - 11:.00 AM. These findings were reviewed with E1 (NHA) and E2 (DON) on 1/11/17 at 3:00 PM .	F 253	F253 Housekeeping & Maintenance Services Individual Resident Impacted The facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Identification of Other Residents with Potential to be Affected All residents in the facility have the potential to be affected. A sweep of the facility was done to identify any and all other resident areas that were in need of housekeeping and maintenance services. Systemic Changes Maintenance and Housekeeping quickly fixed all cited issues and will maintain these repairs. In addition, Maintenance is remodeling all resident rooms, one every other week. Scope of work includes new ceiling tiles; paint ceiling tile track; patch holes; paint room; paint HVAC unit cover; FRP on lower wall to minimize future wall damage; replace cove base; replace floor tiles as needed; change switches and outlets; change over bed lights as needed; and, install plastic over bed light pull cords. Housekeeping then deep cleans the room and strips and waxes the floor. (This will take approx. one year to complete.)	

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F 253	Continued From page 9	F 253	Success Evaluation Housekeeping and Maintenance will do a monthly walk through to ensure that all rooms are up to standards. Meanwhile, if staff reports an issue, it will be addressed immediately. Risk Management will do weekly environmental checks with Housekeeping and Maintenance on resident areas. This will occur for four (4) weeks or until 100% compliance is achieved over three (3) consecutive evaluations. Then, they will conduct monthly audits until we have achieved 100% success. Finally, they will conduct audits one (1) more time a month later. If 100% compliance is achieved, then we will conclude that we have successfully addressed the problems. Maintenance and Housekeeping will submit the results of their walk-throughs to QAA and it will be reviewed by the QA Committee at least quarterly.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the	F 280		4/17/17

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F 280	Continued From page 10 expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 280		

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F 280	Continued From page 11 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to review and revise one (R47) out of 24 stage 2 sampled residents' care plan for falls. Findings include: Review of R47's clinical record revealed: R47's care plan for risk for potential injury related to falls, last updated 11/16/16 included the following interventions: assess for risk of falls and re-evaluate care plan when fall occurs, safety devices high sided mattress to bed at all times	F 280	F280 - Right to Participate in Planning Care / Revise Care Plan Individual Resident Impacted The facility failed to revise the care plan for one (1) resident. The care plan for falls wasn□t updated to include the resident removing her personal alarm. The plan was immediately revised. Identification of Other Residents with Potential to be Affected	

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F 280	Continued From page 12 pressure pad alarm, tab alarm to wheelchair. 12/8/16- an order was written for R47 to wear a personal alarm at all times and for staff to check the personal alarm for function twice a shift. During an interview on 1/9/17 at 11:57 AM with E11 (LPN) when questioned about the circumstances of R47's fall on 12/8/16 E11 confirmed that R47 had removed her personal alarm and has removed it in the past. During an interview on 1/10/17 at 2:29 PM with E10 (RN) charge nurse on R47's unit, it was reported that R47 removes her personal alarm and that staff checks for the placement and function of the personal alarm. During an interview on 1/11/17 at 12:15 PM with E5 (RN) Quality Assurance Nurse Supervisor it was reported that R47 has removed her personal alarm but that it was not added to her care plan because staff has increased observation of the resident since her 12/7/16 fall. These findings were reviewed with E1 (NHA) and E2 (DON) on 1/11/16 at 3:00 PM .	F 280	All residents having a personal alarm have the potential to be affected. Charge Nurses reviewed the care plans; no other issues found. Systemic Changes Root cause: Staff assumed the resident removing her tab alarm was in the careplan. After reviewing, it was determined the resident didn□t need a □tab□ alarm. Her sensor and care plan were changed to a bed sensor. Systemic changes put in place to ensure the deficient practice does not recur: Staff will report alarms being removed by a resident to the Charge Nurse for care plan revisions. QA Supervisor will review personal alarm necessity and effectiveness at the weekly fall/incident report meeting. Corrections to be monitored to ensure the deficient practice will not recur: Monitoring will be completed for updated & accurate fall/alarm documentation in the care plans by the RN Supervisors. Success Evaluation Monitoring will be completed for updated/accurate fall/alarm documentation in the care plans and will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1)	

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	08E029	A. BUILDING _____ B. WING _____	01/11/2017

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F 280	Continued From page 13	F 280	month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documentation it was determined that the facility failed to assess before and/or after	F 309	F309 PROVIDE CARE AND SERVICES FOR HIGHEST WELL BEING.	4/17/17

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F 309	Continued From page 14 PRN pain medication for 1 (R48) out of 24 sampled residents reviewed. Findings include: Facility policy entitled Standardized Procedure / Guideline for Pain Assessment and Management (11/17/11) included the following guideline .. the intensity of pain should be assessed and documented with each new report of pain, after any pain-producing procedure and at suitable intervals and pharmacologic intervention; or non-pharmacologic intervention to evaluate the current pain treatment plan. The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of R48's clinical record revealed: 1/17/13 - Admission to facility with multiple diagnoses including right foot deformity and history of surgical repair of lower extremity fracture [broken bone]. Admission medications included Tylenol to be given every 4 hours PRN for pain. 6/14/13 - Care plan problem for Alteration in comfort related to pain (bilateral lower extremities / generalized pain) included interventions: Assess usual response to pain by verbal report from resident and monitor non-verbal behaviors. Determine current level of pain in reference to	F 309	Individual Resident Impacted The facility failed to assess the intensity level of a resident□s pain before and after administrating medication. Care plan updated. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected. After reviewing the charts no other residents were found affected. Systemic Changes Root Cause: The resident□s care plan stated he could verbally use the 1-10 pain scale. After review with staff, we found the resident would say he was in pain and needed medication but would refuse to vocalize the intensity before and after. The resident□s care plan was changed to use Nonverbal pain scale when needed. Systemic changes put in place to ensure the deficient practice does not recur: MDS coordinators will convey to staff the pain scale needed. This pain scale will be put in the Care Plan. Nursing staff will attend training on pain management including pain scales, assessment and documentation. Corrections to be monitored to ensure the deficient practice will not recur: Audits will be complete for pain management including pain scales, assessment and documentation. Success Evaluation Audits will be complete for pain	

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F 309	Continued From page 15 acceptable level of pain by encouraging verbalization of pain. Ask resident to rate his pain on a scale of 0 - 10 with 10 being the worst possible pain. As a baseline the resident's comfortable pain level is rated as 0 (zero). 11/10/15 - Care plan problem for complications/pain related to broken bones in both feet (last reviewed 10/26/16) included an intervention to utilize the aforementioned care plan for pain. 10/25/16 - Quarterly MDS Assessment documented the resident was cognitively intact but had frequent verbal behavioral symptoms toward others. November, 2016 - December, 2016 PRN MAR and nursing notes - Review discovered 3 out of 6 administrations of the PRN pain medication lacked an assessment of the resident's intensity of pain using the 0 - 10 pain scale before and/or after the administration of the PRN pain medication: - 12/4: before and after - 12/18: before and after - 12/30: after During an interview with E10 (RN, Charge Nurse) on 1/10/17 around 10:30 AM to determine the location of pain assessment information for a PRN pain medication, E10 stated it would be on the PRN MAR and/or the nursing notes. Surveyor showed the missing pain assessments using the numeric pain scale on the back of the MAR and stated that the nursing notes did not include pain intensity. E10 offered no explanation. During an interview with E2 (DON) on 1/11/17	F 309	management including pain scales, assessment and documentation. Following the below schedule will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	

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F 309	Continued From page 16 around 9:25 AM the missing pain assessments were reviewed and confirmed. The findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 309		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to ensure the environment was as free from	F 323	F323 - Free of Accidents Hazards/Supervision/Devices	4/14/17

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F 323	Continued From page 17 accident hazards as possible and failed to provide adequate supervision for one (R48) out of 24 sampled residents. Additionally two (111 and 112) out of 22 rooms reviewed were not free of accident hazards. R48 was found huffing (inhaling fumes) from the alcohol-based hand sanitizer obtained from the automatic dispenser at the nursing station in November, 2015 and during the survey. There was a loose grab bar in the bathroom between rooms 111 and 112. Findings include: 1. Review of R48's clinical record revealed: November, 2016 - December 2016 nursing notes - Review found two documented instances when R48 was seen huffing alcohol-based hand sanitizer. - 11/18/16 (2:58 AM): Resident "continued to wheel back and forth at one time getting sanitizer from the wall dispenser at the nurses station. He then placed his hand with hand sanitizer to his face and inhaled at length. Requests to stop sniffing were ignored then raised the other hand and sniffed that for several minutes all the while grinding his teeth. Eventually he returned to his room." - 11/19/16 (4:40 PM): "Resident observed sniffing hand sanitizer stated 'I'm trying to get high.' 1:1 effective so far. Hand sanitizer [manual dispenser] was removed from resident's possession." Observation on 1/9/17 between 10:00 AM - 10:14 AM: E10 (RN, Charge Nurse) and E7 (NP) were seated side by side at the 1 North nursing station facing the hallway while the surveyor sat at the rear counter facing the back wall of the nursing station. The surveyor saw R48 propel a few feet	F 323	Individual Resident Impacted The facility failed to provide adequate supervision for one (1) resident. The resident was attempting to inhale fumes from hand sanitizer. This was immediately reviewed with staff. The hand sanitizer dispenser was removed from the unit by Maintenance. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected. No other residents were found to have this behavior. Systemic Changes Root Cause: It was found the resident could reach the hand sanitizer dispenser from his wheelchair. Staff didn□t think he was inhaling the sanitizer. When the resident was asked, he stated he was trying to get high. This behavior was added to his care plan. Systemic changes put in place to ensure the deficient practice does not recur: The hand sanitizer dispensers were removed from the wall and place inside locked utility rooms. Corrections to be monitored to ensure the deficient practice will not recur: The hand sanitizer dispensers will not be placed in open areas. Training will be done on completing an incident report for any unsafe practices. Success Evaluation Monitoring will be completed on incident	

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F 323	Continued From page 18 into the side of the nursing station in a wheelchair. The resident reached forward and placed a hand beneath the automatic hand sanitizer machine. After getting hand sanitizer in a hand, R48 pushed backward into the hallway using a foot and was still within view of the surveyor. The resident then rubbed the sanitizer on the palms of both hands then cupped both hands over his nose and mouth and inhaled deeply for several minutes. R48 wheeled away out of surveyor view but returned within a few minutes and returned and repeated this action two more times, for a total of three times. 1/9/17 (10:15 AM) observation: With R48 near the nursing station, the surveyor wrote a note containing the above information and gave it to E10 who then showed it to E7. E7 turned around and commented to the surveyor that the resident said he does that to get high, but the NP (E7) didn't think that getting high could happen. The resident was not seen doing this behavior any more as the surveyor remained at the nursing station. 1/9/17 (11:45 AM): A maintenance employee removed batteries and bag of sanitizer from the dispenser at the nursing station stating that E2 (DON) wants the dispenser moved. 1/10/17 (9:30 AM) - Hand sanitizer dispenser was no longer hanging on the wall in the nursing station. The facility failed to take measures to reduce accident hazards by relocating the automatic hand sanitizer dispenser after R48 was seen doing the same behaviors in November, 2015. The facility failed to adequately supervise this	F 323	reports and resident concerns reports to check for unsafe behavior and will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	

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F 323	Continued From page 19 resident who was known to inhale the smell / fumes from the hand sanitizer (also known as huffing). 2. Rooms 111 and 112 shared a bathroom. On 1/5/16 at 11:50 AM and on 1/11/17 at 10:15 AM one grab bar next to the toilet in the shared bathroom was found to be loose. This finding was confirmed with E8 (Maintenance Director) and E9 (Housekeeping Director) during the environmental tour on 1/11/17 between 10:30 AM - 11:00 AM. These findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 323		
F 329 SS=E	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		4/14/17

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F 329	Continued From page 20 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to consistently assess the effectiveness of PRN medication for anxiety on five (5) occasions for 1 (R48) out of 24 sampled residents for unnecessary medication review. Findings include: Review of R48's clinical record revealed: 1/17/13 - Admitted from a closing facility with multiple diagnoses including anxiety disorder. 7/31/15 - Care plan problem for Alteration in emotional status related to anxiety disorder (last reviewed 10/26/16) included the intervention to administer medications as ordered and monitor for effectiveness and side effects. November - December 2016 - Review of MARs and POSs discovered the resident received a medication for anxiety routinely and had an order for another anxiety medication that could be given by mouth every 8 hours PRN for severe agitation. Five of the 19 PRN administrations of the PRN anxiety medication lacked the assessment of effectiveness on the MAR and / or nursing note. - November: 12, 14, 15 and 30. - December: 15. During an interview with E10 (RN, Charge Nurse) on 1/10/17 around 10:30 AM to determine the location of the effectiveness of the PRN medication for anxiety, E10 stated it would be on the PRN MAR and/or in the nursing notes. After the surveyor explained that several assessments	F 329	F329 - Drug Regimen is Free From Unnecessary Drugs. Individual Resident Impacted The facility failed to consistently assess the effectiveness for a PRN anxiety medication for one (1) resident. Charge Nurses and supervisors reviewed this deficiency will staff. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected. The medication administration record for all residents receiving a PRN medication for anxiety was reviewed. No other resident was identified as receiving a PRN anxiety medication without consistent assessment for effectiveness. Systemic Changes Root Cause: It was found the resident would often refuse to report the effectiveness when asked by the nurse. This wasn□t care planned. Systemic changes put in place to ensure the deficient practice does not recur: The nurse at the end of the shift will review all signed out PRN medications at the end of their shift for assessment completion The RN supervisors will meet with staff and review the requirement to complete assessments. Training in assessment	

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F 329	Continued From page 21 of effectiveness were not on the MAR nor in a nursing note, E10 offered no explanation. During an interview with E2 (DON) on 1/11/17 around 9:25 AM the missing assessments after PRN anxiety medication administration were reviewed and confirmed. These findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 329	documentation will be done. Corrections to be monitored to ensure the deficient practice will not recur: Monitoring will be completed on medication records for accurate assessments. Success Evaluation Monitoring will be completed on medication records for accurate assessments at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		4/3/17

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F 371	Continued From page 22 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to plate and serve meals in a sanitary manner on two (North 1 and South 1) out of 3 units. Findings include: 1. North 1 lunch service observation on 1/9/16 from 11:56 AM - 12:15 PM: - E12 (Food Service Supervisor) was not wearing a beard restraint. - After pushing the steam table into the dining room and plugging it into the outlet, E12 used hand sanitizer, then put on disposable gloves. [E12 did not perform hand hygiene with soap and water before putting on the gloves.] - Using gloved hands E12 pulled the steam table closer and pulled up his pants. [These actions contaminated the gloves. E12 did not remove the gloves, perform hand hygiene and put on new gloves before plating began.] - E12 removed a pre-made sandwich from a plastic bag and placed it on a plate with a hand wearing the contaminated glove. - After removing the gloves, E12 used hand sanitizer [should have been soap and water]	F 371	F371 - Food Procure/Store/Prepare/Serve-Sanitary Individual Resident Impacted Facility failed to plate and serve meals in a sanitary manner on two out of three units. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected by these deficient practices. In response, all current foodservice workers, cooks and supervisors will be in-serviced on the use of beard guards, proper glove usage and handwashing. These in-services will be completed by 2/10/2017. (See Attachment) Systemic Changes: The root-cause of these deficient practices have been determined as a knowledge deficit. In order to ensure that these deficient practices do not reoccur, foodservice workers, cooks and	

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F 371	Continued From page 23 before replacing the metal lids to cover the food on the steam table with bare hands, then placed the tray with bowls and container of potato salad on ice on the shelf below the steam table. 2. South 1 lunch observation on 1/9/17 from 12:17 AM - 12:35 PM: - Wearing a new pair of disposable gloves E12 removed the potato salad and tray with bowls from below the steam table to place on the counter, removed the metal lids covering food items on the steam table. These actions contaminated the gloves. [E12 did not remove the gloves, perform hand hygiene with soap and water and put on new gloves.] -E12 stirred all food items with serving spoons, touching the spoon handles with contaminated gloves. - Three separate times E12 looked through bags of various pre-made sandwiches and removed a bag containing the desired sandwich from below the steam table, opened the bag and removed the sandwich with the contaminated gloved hand and placed it on a plate. - 4 sandwiches were touched with a contaminated gloved hand. According to the professional standards for food safety employees must clean their hands using a procedure that includes rinsing, using a cleaning compound, rubbing together, and then rinsing again. They must clean their hands immediately before donning gloves and after engaging in activities that contaminate the hands. Single-use gloves must be used for only one task. If a beard is present, a beard restraint must be worn by food employees, except those only serving beverages, wrapped food, and wait staff.	F 371	supervisors will receive monthly food safety trainings given by the Foodservice Director or designee. (See Attachment for Lesson Plan Examples) On 1/27/2017 Foodservice Supervisor E12 was informed by Kevin Boyd, Hospital Administrator and Aleisha Stoneberger, RD/LDN that if he has facial hair present, that he must wear a beard guard while serving meals, unless he is only serving beverages or pre-wrapped food items. On 1/27/2017 Foodservice Supervisor E12 was informed by Kevin Boyd, Hospital Administrator and Aleisha Stoneberger, RD/LDN that gloves must be changed after each task change and any time they come into contact with a contaminating surface. E12 was also informed that proper glove usage requires handwashing with soap and water prior to donning a new set of gloves. Success Evaluation The Foodservice Director, Registered Dietitian or designee will perform weekly meal service food safety audits on all 3 resident units. This deficiency will be considered corrected once 100% compliance is reached for 3 consecutive audits. (See Attachment)	

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	08E029	A. BUILDING _____ B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 24 These findings were reviewed with E1 (NHA) and E2 (DON) on 11/11/17 at 3:00 PM.	F 371		
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide the specialized services according to the PASRR Level II evaluation for 1(R48) out of 24 sampled residents. Findings include: Review of R48s clinical record revealed: 7/11/16 - DSAMH (PASRR) Level II Determination of Mental Illness Recommendation documented that R48 required specialized services. The recommended services included an assessment of the resident's mental health needs on at least a	F 406	F406 - Comprehensive Assessments Individual Resident Impacted After the resident returned from the hospital, the PASRR II recommendation was for quarterly assessment by our psychiatrist. GBHC failed to provide services during the third quarter of 2016. Identification of Other Residents with Potential to be Affected All residents with a PASRR II	4/3/17

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F 406	Continued From page 25 quarterly basis by a psychiatrist as well as supportive counseling to be provided by a licensed mental health provider. July, 2016 - December 2016 - Review of the psych notes and consults revealed R48 was receiving regular supportive counseling by a psychologist. A psychiatrist assessment of mental health needs occurred 11/29/16 by Skype [video chat using the computer]. There was no evidence in the record that R48 was seen by a psychiatrist in the third quarter of 2016 (July, August and September). During an interview with E7 (NP) on 1/10/17 at 3:25 PM E7 didn't know about PASRR II recommended specialized services for at least a quarterly psychiatrist assessment. E7 admitted that today was the first time seeing the PASRR II recommendation and that R48 was not ordered for a quarterly assessment by a psychiatrist. During an interview with E6 (Social Service Director) on 1/11/17 around 9:10 AM E6 stated s/he was not aware of the PASRR II recommendation. "I don't know how that got by me." E2 (DON) provided a copy of a 9/30/16 progress note written by E14 (Psychologist) which included "Psychiatric Resident visited resident earlier in the month and he [R48] told him that he [R48] was scared about losing his foot." [The psychiatry resident was making rounds with the psychologist as part of a training program and was not at the facility to conduct a mental health assessment.] This finding was reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 406	recommendation have the potential to be affected. After review, we found this was an isolated case. Services for residents with PASSRR II are being provided. Systemic Changes Any resident who is admitted with level II PASRR requiring specialized services, the Social Service Administrator will review the specialized services needs at our care plan meetings to assure services are being provided. All PASRR II special services will be added to the care plan of each resident. Any resident identified a consult will written by the Nurse Practitioner and signed by the Physician. Success Evaluation New admission and present residents requiring specialized services will be reviewed monthly at our QAA meetings with physician and Director of Nursing. After six (6) months of monthly reviews without evidence of missing services, we will consider our evaluation a success.	

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F 514 SS=B	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R47 and R48) out of 24	F 514	F514 - RESIDENT RECORDS COMPLETE/ACCURATE/ACCESSIBLE	4/17/17

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F 514	Continued From page 27 sampled stage 2 residents the facility failed to maintain accurate and complete medical records. Findings include: Cross refer to F280 1. Review or R47's clinical record revealed: Review of R47's December 2016 hourly safety check log revealed that on 12/16/16 from 10:00 AM through 2:00 PM and on 12/26/16 from 10:00 AM though 2:00 PM there were no signatures provided indicating that R47 was checked on by staff. During an interview on 1/10/17 at 2:29 PM with E10 (RN) charge nurse on R47's unit confirmed that R47 was checked on hourly by staff and that staff did not document the checks. Cross refer F323, example #1 2. Review of R48's clinical record revealed: November, 2016 PRN MAR administration of PRN anxiety medication: - Two times when the date on the back of the MAR did not match the date the medication was given: November 14 (12 th on the back) and November 18 (17 th on the back) - Two administrations of the PRN anxiety medication were omitted on the back of the MAR (November 16 and 30). During an interview with E2 (DON) on 1/11/17 around 9:25 AM, E2 confirmed the inaccuracies. These findings were reviewed with E1 (NHA) and E2 on 1/11/17 at 3:00 PM.	F 514	Individual Resident Impacted 1) Resident R47 hourly safety log was not completed on 12/16/16 10am-2pm & on 12/26/16 from 10am-2pm. 2) Two times The MAR did not match the date the medication was given and the effectiveness of the prn anxiety medication was not documented two times. Identification of Other Residents with Potential to be Affected All residents have the potential to be affected. 1) After reviewing the safety logs, no other resident was found affected. 2) The medication administration record for all residents receiving a PRN medication for anxiety was reviewed. No other resident was identified as receiving a PRN anxiety medication without consistent assessment for effectiveness. Systemic Changes Root Cause: It was found the resident would often refuse to report the effectiveness when asked by the nurse. This wasn□t care planned. The RN supervisors will meet with staff and review the requirement to report changes so the care plan and behavior plan is in place and updated. Systemic changes put in place to ensure the deficient practice does not recur: 1) Safety logs will be reviewed by each shift for completion. PRN anxiety medications assessments will be reviewed by the psychotropic reduction team. To prevent	

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F 514	Continued From page 28	F 514	this from happening again the nurse at the end of the shift will review prn anxiety medications for accurate dates. The RN supervisors will meet with staff and review the requirement for complete and accurate documentation. Corrections to be monitored to ensure the deficient practice will not recur: Safety logs will be checked for completion by the Charge Nurse. Monitoring will be completed on medication records to check for accurate documentation. Success Evaluation Safety logs will be checked for completion by the Charge Nurse. Monitoring will be completed on medication records to check for accurate documentation and will be reviewed at least weekly for twelve (12) weeks or until the facility reaches 100% success over 8 consecutive evaluations. We will then conduct bi-weekly audits until we reach 100% success at three (3) consecutive evaluations. Finally, we will measure practices one (1) month later. If facility is still compliant, then we conclude that we have successfully addressed the problem. These findings will be reviewed at the Quality Assurance Committee meetings (QAPI).	
F 520 SS=F	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance.	F 520		4/10/17

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F 520	Continued From page 29 (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on review of facility documentation and	F 520	F520 - QAA Committee Quarterly	

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F 520	Continued From page 30 interview it was determined that the facility failed to ensure quality assurance (QA) meetings were conducted at least quarterly. Findings include: The facility provided attendance sign-in sheets for QA meetings for the following dates: 2/23/16, 6/23/16, 8/25/16 and 10/20/16. An interview on 1/11/17 at 9:35 AM with E5 (Quality Assurance Administrator) revealed that the QA meeting due in May, 2016 was not conducted until 6/23/16 due to an extended staff absence. It was further revealed that although the Quality Assurance Nurse Supervisor continued to conduct monitoring and evaluation, facility administration did not conduct the quarterly meeting. Findings were reviewed with E1 (NHA) and E2 (DON) on 1/11/17 at 3:00 PM.	F 520	Meetings Individual Resident Impacted GBHC QAA meetings went beyond the required quarterly meetings by one (1) month in May 2016. Identification of Other Residents with Potential to be Affected All residents living at GBHC have the potential to be affected Systemic Changes QAA meetings will be held monthly the third Thursday of every month beginning with February 16, 2017. Success Evaluation GBHC will have fulfilled the Federal and State requirements of QAA meetings at least quarterly when done monthly. These findings will be reviewed at the Quality Assessment and Assurance (QAA) Committee meetings at least quarterly.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Governor Bacon Health Center

DATE SURVEY COMPLETED: January 11, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced annual survey was conducted at this facility from January 4, 2017 through January11, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and other facility documentation as indicated. The facility census the first day of the survey was sixty (60). The survey sample totaled twenty-four (24).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.10	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**		

Provider's Signature Lisa M. Rago Title Director Date 2/20/17

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	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed January 11, 2017: F0166, F0167, F0253, F0280, F0309, F0323, F0329, F0371, F0406, F0514, F0520	Cross reference to the CMS-2567(02-99) survey report date completed 1/11/17: FO166, FO167, FO253, FO280, FO309, FO323, FO329, FO371, FO406, F)514, FO520.	

Provider's Signature _____ Title _____ Date _____